FOR OHF USE

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037556

Facility Name: Columbia Convalescent Center

Address: 253 Bradington Dr. (Number) Columbia (City) 62236 (Zip Code)

County:

Telephone Number: 618-281-6800 **Fax #** 618-281-6557

IDPA ID Number: 37-1280633001

Date of Initial License for Current Owners: 12/19/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: David Wendler **Telephone Number:** 618-281-6800
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) David Wendler
(Title) Administrator

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) Fax # 618-281-6557

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	119	Skilled (SNF)	119	43,435	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	119	TOTALS	119	43,435	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	998	3,353	1,467	5,818	8
9	SNF/PED					9
10	ICF	14,198	17,241		31,439	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,196	20,594	1,467	37,257	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.78%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/1/91

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 12 and days of care provided 1,467

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	197,307	9,659	5,574	212,540		212,540		212,540			1
2	Food Purchase		166,132		166,132		166,132	(2,953)	163,179			2
3	Housekeeping	142,675	11,747	89	154,511		154,511		154,511			3
4	Laundry	52,900	14,732	8,600	76,232		76,232		76,232			4
5	Heat and Other Utilities			136,994	136,994		136,994		136,994			5
6	Maintenance	65,462	22,871	24,672	113,005		113,005		113,005			6
7	Other (specify):*											7
8	**TOTAL General Services**	458,344	225,141	175,929	859,414		859,414	(2,953)	856,461			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,610,538	28,912	20,933	1,660,383	11,916	1,672,299		1,672,299			10
10a	Therapy	49,147		127,514	176,661	(11,916)	164,745		164,745			10a
11	Activities	72,799	9,135		81,934		81,934		81,934			11
12	Social Services	45,351	104	475	45,930		45,930		45,930			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,777,835	38,151	157,922	1,973,908		1,973,908		1,973,908			16
	C. General Administration											
17	Administrative	88,866		216,351	305,217		305,217		305,217			17
18	Directors Fees											18
19	Professional Services			18,771	18,771	(2,531)	16,240		16,240			19
20	Dues, Fees, Subscriptions & Promotions			22,569	22,569		22,569	(5,334)	17,235			20
21	Clerical & General Office Expenses	120,144	8,652	37,884	166,680		166,680		166,680			21
22	Employee Benefits & Payroll Taxes			400,743	400,743		400,743		400,743			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,839	1,839		1,839		1,839			24
25	Other Admin. Staff Transportation			1,758	1,758		1,758		1,758			25
26	Insurance-Prop.Liab.Malpractice			199,420	199,420		199,420		199,420			26
27	Other (specify):*			7,609	7,609		7,609	(7,609)				27
28	**TOTAL General Administration**	209,010	8,652	906,944	1,124,606	(2,531)	1,122,075	(12,943)	1,109,132			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,445,189	271,944	1,240,795	3,957,928	(2,531)	3,955,397	(15,896)	3,939,501			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.
**** See schedule of adjustment attached at end of cost report.**

Facility Name & ID Number Columbia Convalescent Center #0037556 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			168,349	168,349		168,349		168,349			30
31	Amortization of Pre-Op. & Org.			2,760	2,760		2,760		2,760			31
32	Interest			108,786	108,786		108,786	(223)	108,563			32
33	Real Estate Taxes			76,811	76,811	2,531	79,342		79,342			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,085	3,085		3,085		3,085			35
36	Other (specify):*											36
37	**TOTAL Ownership**			359,791	359,791	2,531	362,322	(223)	362,099			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		35,328	2,691	38,019		38,019		38,019			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		5,416		5,416		5,416		5,416			41
42	Provider Participation Fee			65,153	65,153		65,153		65,153			42
43	Other (specify):* Nonallowable Costs			7,596	7,596		7,596		7,596			43
44	**TOTAL Special Cost Centers**		40,744	75,440	116,184		116,184		116,184			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,445,189	312,688	1,676,026	4,433,903		4,433,903	(16,119)	4,417,784			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,953)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,238)	27		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(223)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(50)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,371)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,284)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (16,119)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (16,119)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Columbia Convalescent Center

ID# 0037556

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Columbia Convalescent Center **#** 0037556 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,953)	0	0	0	0	0	0	0	0	0	0	(2,953)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,953)	0	0	0	0	0	0	0	0	0	0	(2,953)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(5,334)	0	0	0	0	0	0	0	0	0	0	(5,334)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(7,609)	0	0	0	0	0	0	0	0	0	0	(7,609)	27
28	**TOTAL General Administration**	(12,943)	0	0	0	0	0	0	0	0	0	0	(12,943)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(15,896)	0	0	0	0	0	0	0	0	0	0	(15,896)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Columbia Convalescent Center # 0037556 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(223)	0	0	0	0	0	0	0	0	0	0	(223)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(223)	0	0	0	0	0	0	0	0	0	0	(223)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(16,119)	0	0	0	0	0	0	0	0	0	0	(16,119)	45

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Steve Wolf	50.00%	Eldercare of Alton/Calvin Johnson Care Center	Belleville/Alton	Eldercare/SAMAS	Belleville	Mgmt Co.
Michael Riley	16.00%	Collinsville Care Center	Collinsville	SAMAS	Belleville	Mgmt Co.
Minority Shareholders	34.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	$ 216,351	SAMAS PARTNERSHIP	0.00%	$ 216,351	$	1
2	V	17	Administrator Bonus	7,000	SAMAS PARTNERSHIP	0.00%	7,000		2
3	V	21	Bank Charges	120	SAMAS PARTNERSHIP	0.00%	120		3
4	V	19	Accounting Fees	340	SAMAS PARTNERSHIP	0.00%	340		4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 223,811			$ 223,811	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Steve Wolf	President	Owner/Admin	50.00	A 169464	10	14.00	Mgmt fees	$ 118,474	17-3	1
2	Michael Riley	Secretary	Owner/Admin	16.00	0	20	30.00	Mgmt fees	59,388	17-3	2
3	Steven Brant	Treasurer	Owner/Admin	4.00	B 71793	10	17.00	Mgmt fees	38,489	17-3	3
4											4
5											5
6		A- Eldercare, Inc.									6
7											7
8		B- Four Fountains									8
9											9
10											10
11											11
12											12
13								TOTAL	$ 216,351		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Union Planters		X	Mortgage Original	$21,665.39	3/6/02	$ 2,740,484	$ 1,833,755	3/6/07	3.6250	$ 69,573	1
2	Union Planters		X	Mortgage New Addition	$7,518.65	3/6/02	925,720	786,522	3/6/07	3.6250	29,719	2
3	Union Planters		X	Mortgage New Addition	$2,618.34	3/6/02	300,000	250,853	3/6/07	3.6250	9,494	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$31,802.38		$ 3,966,204	$ 2,871,130			$ 108,786	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,966,204	$ 2,871,130			$ 108,786	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.		$ 77,744	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2002	$ 77,278	2
3. Under or (over) accrual (line 2 minus line 1).		$ (466)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 77,278	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 2,531	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 79,343	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	65,350	8
	1999	78,005	9
	2000	80,068	10
	2001	77,744	11
	2002	77,278	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Columbia Convalescent Center COUNTY Monroe

FACILITY IDPH LICENSE NUMBER 0037556

CONTACT PERSON REGARDING THIS REPORT David Wendler

TELEPHONE 618-281-6800 FAX #: 618-281-6557

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-17-481-028-000	Lot 2 & Pt Lot 1 Bradington Pl	$ 56,215.98	$ 56,215.98
2.	04-17-481-005-000	Part Lot 4 Sur 416	$ 20,423.82	$ 20,423.82
3.	04-17-481-004-000	Part Lot 4 Sur 416	$ 637.80	$ 637.80
4.	04-17-481-003-000	Pt lot 1 Bradington Pl.	$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 77,277.60	$ 77,277.60

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,079 B. General Construction Type: Exterior Brick Frame Concrete/Steel Number of Stories

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	189,566	1991	$ 249,469	1
2	Resident Care	21,364	1993	28,115	2
3	TOTALS	210,930		$ 277,584	3

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1991	1991	$ 2,115,587	$ 52,890	40	$ 52,890	$	$ 687,566	4
5			1991	1991	48,503	3,234	40	3,234		38,803	5
6	10		1998	1998	1,170,228	29,256	40	29,256		158,468	6
7											7
8											8
	Improvement Type**										
9	Land Improvements			1991	147,905	7,395	20	7,395		89,359	9
10	Fixed Equipment			1991	24,679	1,645	18	1,645		19,741	10
11	Alarm System			1992	910	61	15	61		728	11
12	Water Softner			1992	8,625	575	12	575		6,325	12
13	Carpet			1993	1,430		12			1,430	13
14	Guttering			1994	899		8			870	14
15	Pavillion			1994	7,400	617	12	617		5,858	15
16	Misc Improvements			1995	2,165		10			2,165	16
17	Drainage System			1996	1,374	92	15	92		656	17
18	Cold Water Line			1996	6,803	174	39	174		1,337	18
19	A/C Compressor			1996	1,574	187	7	187		1,574	19
20	Carpet			1996	591	70	7	70		591	20
21	Hot Water Heater			1996	3,473	413	7	413		3,473	21
22	Heat Trace & Hot Water Pipes			1996	1,535	102	15	102		708	22
23	Furnace and Air conditioning renovation			1997	1,690	169	10	169		1,113	23
24	Day Room Carpet and Window Treatments			1997	7,658	1,094	7	1,094		4,548	24
25	Telephone/Voice Mail System			1997	14,739		5			14,739	25
26	Entry Area Carpeting			1997	1,080	154	7	154		977	26
27	UPS Battery Back-up System			1997	733		5			733	27
28	Door			1997	1,485	38	39	38		234	28
29	Fan			1997	1,083	28	39	28		171	29
30	Landscaping			1998	4,030	269	15	269		1,384	30
31	Landscaping			1998	7,429	495	15	495		2,683	31
32	Irrigation System			1998	12,990	866	15	866		4,691	32
33	Parking Lot			1998	15,912	1,061	15	1,061		5,746	33
34	Landscaping			1998	10,479	699	15	699		3,784	34
35	Sidewalks			1998	19,864	1,324	15	1,324		7,173	35
36	Draperies & Window Treatments			1998	18,417	2,144	5	2,144		18,415	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Flooring & Carpeting	1998	$ 36,840	$ 3,684	10	$ 3,684	$	$ 23,029	37
38	Decorating Wallpapering & Painting	1998	49,156	6,022	5	6,022		48,887	38
39	Alarm Security System	1998	17,574	2,257	5-7y	2,257		13,690	39
40	Attic Ventilating Fans	1998	6,179	618	10	618		3,501	40
41	Storeroom Locks	1998	593	85	7	85		431	41
42	Telephone Equipment	1998	1,940	194	10	194		1,083	42
43	Light Fixtures	1998	4,291	429	10	429		2,324	43
44	Therapy Room Sink	1998	1,213	173	7	173		880	44
45	Signage	1998	116	12	10	12		63	45
46	Site Lighting	1998	5,684	812	7	812		4,398	46
47	Landscaping	1999	6,955	464	15	464		2,037	47
48	Water Heater Replacement	1999	35,258	3,529	10	3,529		15,987	48
49	Washer & Dryer	1999	4,600	460	10	460		1,878	49
50	Air Conditionner	1999	8,965	896	10	896		3,865	50
51	Room Renovations	1999	6,778	929	5-10y	929		4,362	51
52	Door Security System	1999	14,347	1,435	10	1,435		6,315	52
53	Landscaping	2000	1,987	132	15	132		441	53
54	Water Heater Replacement	2000	6,848	685	10	685		2,682	54
55	Carpeting	2000	1,579	158	10	158		553	55
56	Floor Tile	2001	1,546	155	10	155		451	56
57	Landscaping	2001	2,127	142	10	142		371	57
58	Evaporator Coil	2001	2,514	251	10	251		649	58
59	Vinal Trim Window	2001	6,459	646	10	646		1,400	59
60	Painting	2001	6,080	608	10	608		1,267	60
61	Telephone System	2001	1,631	326	10	326		680	61
62	Alert System	2001	6,443	920	7	920		1,610	62
63	Alert System	2002	6,442	921	7	921		1,611	63
64	Landscaping	2002	417	28	15	28		49	64
65	Heating Cooling	2002	7,477	748	10	748		1,186	65
66	Carpeting, fire doors, electrical	2002	4,968	497	10	497		682	66
67	Parking Lot	2003	3,420	19	15	19		19	67
68	Hot Water Heater	2002	2,380	238	10	238		456	68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,924,076	$ 133,525		$ 133,525	$	$ 1,232,880	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,924,076	$ 133,525		$ 133,525	$	$ 1,232,880	1
2									2
3	Bathroom impr	2003	624	16	10	16		16	3
4	Air Conditioning/temp control	2003	3,603	90	10	90		90	4
5	Nurse Call System	2003	1,075	18	10	18		18	5
6	Hot water system	2003	5,603	374	10	374		374	6
7	Payroll wiring/ time system	2003	2,000	167	10	167		167	7
8	Valves,adapters, coils A/C	2003	3,626	238	10	238		238	8
9	Security upgrades	2003	522	30	10	30		30	9
10	Control joints	2003	1,019	68	10	68		68	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,942,148	$ 134,526		$ 134,526	$	$ 1,233,881	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 335,532	$ 33,039	$ 33,039	$	5-10 yr	$ 194,187	71
72	Current Year Purchases	11,055	784	784		5-10 yr	784	72
73	Fully Depreciated Assets	339,550					339,550	73
74								74
75	TOTALS	$ 686,137	$ 33,823	$ 33,823	$		$ 534,521	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	1994 Ford Van	1993	$ 38,214	$	$	$	5	$ 38,214	76
77										77
78										78
79										79
80	TOTALS			$ 38,214	$	$	$		$ 38,214	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,944,083	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 168,349	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 168,349	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,806,616	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/03 Ending: 12/31/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 3,085 Description: Office 462/Nursing 1442/Dietary 1181
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10-A-3	hrs	$	853	$ 49,606	$	853	$ 49,606	1
2	Licensed Speech and Language Development Therapist	10-A-3	hrs		128	10,080		128	10,080	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10-A-3	hrs		943	55,912		943	55,912	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				35,328		35,328	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab/X-Ray	39-3				2,521			2,521	13
14	TOTAL			$	1,924	$ 118,119	$ 35,328	1,924	$ 153,447	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Columbia Convalescent Center
Provider #: 0037556
01/01/03 to 12/31/03

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies
	L39, C3			
	L39, C3			
	L39, C3			
	L39, C3			
Total			0	0

See Accountants' Compilation Report

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 185,796	$	1
2	Cash-Patient Deposits	6,613		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	367,713		3
4	Supply Inventory (priced at cost)	18,720		4
5	Short-Term Investments			5
6	Prepaid Insurance	76,975		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 655,817	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	277,583		13
14	Buildings, at Historical Cost	3,942,147		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	724,351		16
17	Accumulated Depreciation (book methods)	(1,806,092)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Constr Period Int (Net)	25,671		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,163,660	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,819,477	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 58,301	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,613		28
29	Short-Term Notes Payable	200,966		29
30	Accrued Salaries Payable	105,788		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,625		31
32	Accrued Real Estate Taxes(Sch.IX-B)	77,278		32
33	Accrued Interest Payable	7,129		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Duee to Mgmt Co.	4,811		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 466,511	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,670,164		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,670,164	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,136,675	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 682,802	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,819,477	$	48

***(See instructions.)**

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 654,267	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 654,267	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	508,536	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(480,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**	(1)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 28,535	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 682,802	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,706,617	1
2	Discounts and Allowances for all Levels	(105,548)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,601,069	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	201,786	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 201,786	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	8,209	12
13	Barber and Beauty Care	6,800	13
14	Non-Patient Meals	2,953	14
15	Telephone, Television and Radio	3,910	15
16	Rental of Facility Space		16
17	Sale of Drugs	86,362	17
18	Sale of Supplies to Non-Patients	10,697	18
19	Laboratory	10,876	19
20	Radiology and X-Ray	923	20
21	Other Medical Services	673	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 131,403	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	223	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 223	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc income	581	28
28a	medical equipment rental	7,377	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,958	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,942,439	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	859,414	31
32	Health Care	1,973,908	32
33	General Administration	1,124,606	33
	B. Capital Expense		
34	Ownership	359,791	34
	C. Ancillary Expense		
35	Special Cost Centers	51,031	35
36	Provider Participation Fee	65,153	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,433,903	40
41	**Income before Income Taxes (line 30 minus line 40)****	508,536	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 508,536	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** N/A **If not, please attach a reconciliation.** **return on extension**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,927	2,169	$ 78,126	$ 36.02	1
2	Assistant Director of Nursing	1,991	2,188	48,327	22.09	2
3	Registered Nurses	7,068	7,857	180,393	22.96	3
4	Licensed Practical Nurses	21,906	23,705	434,036	18.31	4
5	Nurse Aides & Orderlies	71,470	76,757	869,656	11.33	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,372	3,772	49,147	13.03	8
9	Activity Director					9
10	Activity Assistants	7,174	7,687	72,799	9.47	10
11	Social Service Workers	2,761	3,042	45,351	14.91	11
12	Dietician					12
13	Food Service Supervisor	1,995	2,189	29,850	13.64	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,728	19,116	167,457	8.76	15
16	Dishwashers					16
17	Maintenance Workers	4,854	5,179	65,462	12.64	17
18	Housekeepers	13,483	14,455	142,675	9.87	18
19	Laundry	5,579	5,920	52,900	8.94	19
20	Administrator	1,896	2,120	88,866	41.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,443	9,150	120,144	13.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	171,647	185,306	$ 2,445,189 *	$ 13.20	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	75	$ 3,740	1-3	35
36	Medical Director	monthly	9,000	9-3	36
37	Medical Records Consultant	21	833	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	720	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	15	475	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	135	$ 14,768		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	100	$ 3,463	10-3	50
51	Licensed Practical Nurses	215	7,459	10-3	51
52	Nurse Aides	237	4,623	10-3	52
53	TOTAL (lines 50 - 52)	552	$ 15,545		53

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
David Wendler	Administrator	0	$ 88,866
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 88,866

B. Administrative - Other

Description	Amount
Management fees to SAMAS	$ 216,351
TOTAL (agree to Schedule V, line 17, col. 3)	$ 216,351
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Newman Freyman & Klein	Legal	$ 473
Duane & Morris	Legal	2,863
Wessel & Pautsch	Legal	120
J W Boyle	Accounting	10,810
Moore Renner & Simonin	Accounting	686
Corp Cost Solutions	Payroll Audit	1,288
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 16,240

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 87,742
Unemployment Compensation Insurance	20,255
FICA Taxes	182,261
Employee Health Insurance	88,842
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	2,271
Scholorships	7,983
Employee relations	11,389
TOTAL (agree to Schedule V, line 22, col.8)	$ 400,743

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
	N/A	
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 4,380
Advertising: Employee Recruitment	3,645
Health Care Worker Background Check	708
(Indicate # of checks performed 59)	
Illinois Sec State	650
City License	193
HIPAA Website/manual	306
Illinois Health Care	6,426
UB92 manuals	260
Misc dues, fees and subscriptions	667
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,235

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,839
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,839

**See instructions.

Columbia Convalescent Center
Provider #: 0037556
01/01/03 to 12/31/03

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	16,240
Allocated from Management Company	
Total (agree to Schedule V, line 19, column 8)	16,240

See Accountants' Compilation Report

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9						N/A							
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Columbia Convalescent Center # 0037556 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA 6426**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-15**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **0** Line

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **65,153**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Columbia Convalescent C** **11:31 AM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-16,119	equal to	-16,119	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	108,786	equal to	108,563	223	FAILED	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	79,343	equal to	79,342	1	FAILED	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	2,760	-2,760	FAILED	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	168,349	equal to	168,349	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	3,085	equal to	3,085	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	115,598	equal to	176,661	-61,063	FAILED	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	35,328	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	859,414	equal to	859,414	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,973,908	equal to	1,973,908	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,124,606	equal to	1,124,606	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	359,791	equal to	359,791	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	51,031	equal to	51,031	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	65,153	equal to	65,153	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,610,538	equal to	1,610,538	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	72,799	equal to	72,799	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	45,351	equal to	45,351	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	197,307	equal to	197,307	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	65,462	equal to	65,462	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	142,675	equal to	142,675	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	52,900	equal to	52,900	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	88,866	equal to	88,866	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	120,144	equal to	120,144	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	2,445,189	equal to	2,445,189	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	3,740	< or = to	5,574	-1,834	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	9,000	< or = to	9,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	17,098	< or = to	20,933	-3,835	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to		0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	475	< or = to	475	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	88,866	equal to	88,866	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	216,351	equal to	216,351	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	16,240	equal to	18,771	-2,531	FAILED	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	400,743	equal to	400,743	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	17,235	equal to	17,235	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	1,839	equal to	1,839	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	65,153	equal to	65,153	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to		0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,467	equal to	1,467	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs		equal to	0	#VALUE!	#VALUE!	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	2,871,130	equal to	0	2,871,130	FAILED	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	77,278	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	277,584	equal to		0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	3,942,148	equal to	0	3,942,148	FAILED	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	724,351	equal to		0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,806,616	equal to	#VALUE!	#VALUE!	#VALUE!	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	682,802	equal to	682,802	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	508,536	equal to	508,536	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	3,819,477	equal to	3,819,477	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

Enter Cost Center Expenses	**YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINK**					
	TO THE COST REPORT!!		11/04/05	11:31:44 AM		
HSA Number	?	Name	**Columbia Convalescent Center**			
Cost report period	From:	01/01/03	To:	12/31/03	Base Number	336
If this is an ICF/DD 16 facility, enter a 1 in cell C		N				
Licensed bed days:	43,435	Occupancy:	37,257	Pct. of occupancy:	85.78%	
Illinois Public Aid Support Rate		$				
Genl Services Salary/Wage:	458,344	Col 1, Line 8 ---Audit Adj:				
Genl Admin Salary/Wage	209,010	Col 1, Line 28 ---Audit Adj				
Total Salary Wage	2,445,189	Col 1, Line 44 ---Audit Adj				
Employee Benefits	400,743	Col 8, Line 22 ---Audit Adj				
Total General Services:	856,461	Col 8, Line 8 ---Audit Adj:				
Total General Admin	1,109,132	Col 8, Line 28 ---Audit Adj				

Instructions and Calculation Steps

STEP Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amou out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amou by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to you total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8	$458,344
Divided by Total Wages (Column 1, Line 44	$2,445,189
General service wages as percent of total wages	18.7447%
Employee Benefits (Column 10, Line 22	$400,743
Allocation of Employee Benefits to General Services Costs	$75,118
Plus Total General Services (Column 10, Line 8	$856,461
New Total General Services Cost	$931,579

B. General Administration

1 Determine the proportion of General Administratio wages to total wages.

2 Multiply the total lump sum fringe amount by th proportion to get the fringes amount for General Administration

3 Add the proportioned fringe amount to your tota General Administration expenses

4 Subtract the total lump sum fringe amount from you General Administration expenses to get your new total General Administration Cost

General Administration Wages (Column 1, Line 28	$209,010
Divided by Total Wages (Column 1, Line 45	$2,445,189
General administration wages as a percent of total wages	8.5478%
Employee Benefits (Column 10, Line 22	$400,743
Allocation of Emplayee Benefits to General Admin. Cost	$34,255
Plus Total General Administration (Column 10, Line 2	$1,109,132
Minus Total Fringe (Column 10, Line 2:	$400,743
New Total General Administration Cos	$742,644

STEP Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflatior fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To selec the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select th inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month	13	divided by 2 =	6.5
Beginning Day + Ending Day	32	divided by 60.8 =	0.526315789
Beginning Year + Ending Year =	206	multiplied by 6 =	1236
Sum of the three lines			1243.026316
Subtract from the sum			907.00
Base Number (expressed as a whole number, fraction dropped)			336

B. Select the Appropriate Inflation Multiplier

Refer to Table I, inflation Multipliers, and find th multipliers which correspond with the base number you have calculated.

General Services Multiplier	1
General Administration Multiplie	1

C. Apply Inflation Multipliers to Update Cos

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table

New Total General Service Cost (Step I-A)	$931,579	
General Services Multiplier (Step II-B	1	
Updated General Services Cost		$931,579

2 Multiply New Total General Administration Cos (from Step I-B)by the appropriate multiplier from Table

New Total General Service Cost (Step I-B	$742,644	
General Administration Multiplier (Step II-E	1	
Updated General Services Cost		$742,644
3 Total Updated Support Costs (1 + 2		$1,674,223

STEP I Convert Total Updated Support Costs (C-3) to Per Diem Cos

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT CO $43.71

A. If the occupancy (Cost Report, Page 2, Schedule III-C) i equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patien days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14

Total Support Costs (Step II, C, 3, above	$1,674,223
Total Patient Days (Cost Report	37,257
Support Costs per Dien	$44.94

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A Column 4, Line 7). Then subtract the total patier days (Cost Report, Page 2, Schedule III-B, Column 5 Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above by your adjusted occupancy.

Licensed Bed Days	43,435
Multiplied by	0.93
	40,395
Minus total Patient Day	37,257
	3,138
One-third of difference	1,046
Plus Total Patient Day	37,257
Adjusted Occupancy	38,303
Total Support Costs (Step II, C, 3, above	$1,674,223
Divided by Adjusted Occupany	38303
Support Costs Per Dien	$43.71

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75t percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to c greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table I

B. If your support costs per diem from Step III is equal to o greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	#N/A
Minus Support Costs Per Dier	$43.71
Difference	#N/A
Multiply the Difference by	0.5
One-Half of the Difference	#N/A
Plus Support Costs Per Dier	$43.71
Support Rate if costs are between 35th and 75th percentile	#N/A

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	#N/A
Minus Support Costs Per Dier	$43.71
Difference	#N/A
Multiply the Difference by	0.5
One-Half of the Difference	#N/A
Compare one-half the difference to the profit ceiling for your HSA in Table II and	#N/A
Enter the Lower of the Two Amounts	#N/A
Plus Support Costs Per Dier	$43.71
Support Rate if support costs less than 35th percentile	#N/A

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C abc **#N/A**

75th Percentile is	#N/A
35th Percentile is	#N/A

Table
Inflation Multiplier

Base Number	General Services Multiplie	General Administration Multiplie
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table I
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	40.08	32.10	4.040
2	37.33	31.77	2.830
3	34.36	29.73	2.365
4	37.33	31.77	2.830
5	32.69	27.53	2.630
6	43.80	31.76	6.070
7	43.80	31.76	6.070
8	43.80	31.76	6.070
9	39.02	30.77	4.175
10	40.08	32.10	4.040
11	35.80	29.99	2.955

Table II (For ICF/DD 16 Facilities)
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	34.86	27.19	3.885
2	33.30	25.97	3.715
3	32.74	25.54	3.650
4	33.30	25.97	3.715
5	30.46	23.75	3.405
6	40.44	31.54	4.500
7	40.44	31.54	4.500
8	40.44	31.54	4.500
9	37.60	29.32	4.190
10	34.86	27.19	3.885
11	32.73	25.52	3.655

Capital Rate Data
Change print Orientation!

YOU HAVE CHOSEN THE CAPITAL CALC. THAT IS LINKED TO THE COST REPORT!!!! 11/04/05 11:31:44 AM
COSTS INCLUDED ON PAGES 12 THRU 12D START AT CELL O6

Facility Name: **Columbia Convalescent Center** ID: **0037556**

HSA No.: ? Own or Rent? (O or R) ______ Own or Rent Beginning: ______

IF RENTED, have facilities been continously rented from an unrelated party since prior to January 1, 1978 (Y or N): or since the first day of operation for buildings constructed since January 1, 1978? N

Cost Report Pd:		Licensed Beds:	119	Total Patient Days	37,257
Begin	**01/01/03**	Licensed Bed Days:	43,435	% Occupied	85.78%
End	**12/31/03**			Capital Days	40,395

1989 Property Tax COST: ______ (Actual dollar amount 1989 taxes)

1991 Property Tax RATE: ______ (Inflated dollar amount divided by 1991 capital days)

FY 1991 Capital Rate: ______ (From form 787)

CAPITAL CALCULATIONS

	Calculation Column
A. Determine the base year for your building from Work Table A	1993
B. Determine the Building Specific historical cost per bed:	
1. Work Table A, Line 24, Column (B)	3942148.02
2. Total licensed beds from cost report Page 2, Line 7, column 3	119
3. Line 1 divided by Line 2	$33,127
4. Regional construction inflator from Table 2	#N/A
5. Building specific historical Cost ber bed (Line 3 * Line 4, round to even $)	#N/A
C. Obtain the Uniform Building Value from Table 1	#VALUE!
D. The capital rate will be calculated through a blending of the uniform building value from Line C and the building specific historical cost per bed from Line B5	
1. Building specific historical cost from Line B5	#N/A
2. Uniform building value from Line C	#VALUE!
3. Add Lines 1 and 2	#VALUE!
4. Divide by 2 to obtain average	#VALUE!
5. Enter 120% of line C	#VALUE!
6. The blended value is the lesser of Line 4 or Line 5	#VALUE!
E. Divide the blended value from step D by 339 days to obtain a per diem blended value investment	#VALUE!
F. Multiply the per diem blended value from step E by the applicable rate of return to obtain the building rate factor. (The rate of return is 11% for 1979 and later base years and 9.13% for 1978 and older base years.)	#VALUE!
G. Add $2.50 to Line F for equipment, rent, vehicle and working capital.	2.5
H. Add Lines F & G to obtain the preliminary capital rate	#VALUE!
I. Implementation Capital Rate. (This step does not apply if the facility has been constructed or purchased after FY91.)	
1. Enter the FY 91 capital rate	0
2. Subtract the FY 91 property tax rate	0
3. FY 91 rate without tax	0
4. Multiply Line I3 by 115%	x 1.15%
5. Implementation capital rate	0

J. Property Tax
Property taxes are taken from the Long Term Care Property Tax Statement which was submitted to the Department of Public Aid during FY93. Reimbursement for real estate taxes is based upon the actual 1991 taxes for which the nursing homes were assessed. The formula used is a follows:

1. Property Tax Expense (Long Term Care Property Tax Statement, Column D, Total.)	0
2. Divided by: Capital Days (see below)	40,395
3. Equals: Per Diem Cost	$0.00
4. Times: Property Tax Inflator (Table 3)	#N/A
5. Equals: Updated Property Tax Cost	#N/A

Capital Days
The capital days are the higher of the actual census (Page 2, Schedule III-B, Column 5, Line 14) or 93% of licensed bed days (page 2, Schedule III-A, Column 4, Line 7 * .93.)

1. Total Patient Days	37,257
2. Total Licensed Bed Days * .93	40395
3. Capital Days (higher of Line 1 or Line 2)	40,395

K. Total Capital Rate for FY 94

1. Enter the greater of the simplified system rate from Line H or the implementation capital rate from Line I	#VALUE!
2. Add Property Tax from Line J5	#N/A
3. Total capital rate (add Lines 1 & 2)	#VALUE!

WORK TABLE A

		Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
1	1	91	2115587	192518417	12
2	2	91	48503	4413773	12
3	3	98	1170228	114682344	12
4	4	0	0	0	12
5	5	0	0	0	12
6	6	91	147905	13459355	12
7	7	91	24679	2245789	12
8	8	92	910	83720	12
9	9	92	8625	793500	12
10	10	93	1430	132990	12
11	11	94	899	84506	12
12	12	94	7400	695600	12
13	13	95	2165	205675	12
14	14	96	1374	131904	12
15	15	96	6803	653088	12
16	16	96	1574	151104	12
17	17	96	591	56736	12
18	18	96	3473	333408	12
19	19	96	1535	147360	12
20	20	97	1690	163930	12
21	21	97	7658	742826	12
22	22	97	14739	1429683	12
23	23	97	1080	104760	12
24	24	97	733	71101	12
25	25	97	1485	144045	12
26	26	97	1083	105051	12
27	27	98	4030	394940	12
28	28	98	7429	728042	12
29	29	98	12990	1273020	12
30	30	98	15912	1559376	12
31	31	98	10479	1026942	12
32	32	98	19864	1946672	12
33	33	98	18417	1804866	12
34	34	98	36840	3610320	12A
35	35	98	49156	4817288	12A
36	36	98	17574	1722252	12A
37	37	98	6179	605542	12A
38	38	98	593	58114	12A
39	39	98	1940	190120	12A
40	40	98	4291	420518	12A
41	41	98	1213	118874	12A
42	42	98	116	11368	12A
43	43	98	5684	557032	12A
44	44	99	6955	688545	12A
45	45	99	35258	3490542	12A
46	46	99	4600	455400	12A
47	47	99	8965	887535	12A
48	48	99	6777.89	671011.11	12A
49	49	99	14347	1420353	12A
50	50	100	1987	198700	12A
51	51	100	6848	684800	12A
52	52	100	1579	157900	12A
53	53	101	1546.15	156161.15	12A
54	54	101	2127	214827	12A
55	55	101	2514	253914	12A
56	56	101	6459.3	652389.3	12A
57	57	101	6080	614080	12A
58	58	101	1630.9	164720.9	12A
59	59	101	6442.5	650692.5	12A
60	60	102	6442	657084	12A
61	61	102	417	42534	12A
62	62	102	7476.63	762616.26	12A
63	63	102	4967.65	506700.3	12A
64	64	103	3420	352260	12A
65	65	102	2380	242760	12A
66	66	0	0	0	12A
67	67	0	0	0	12B
68	68	103	624	64272	12B
69	69	103	3603	371109	12B
70	70	103	1075	110725	12B
71	71	103	5603	577109	12B
72	72	103	2000	206000	12B
73	73	103	3626	373478	12B
74	74	103	522	53766	12B
75	75	103	1019	104957	12B
76	76	0	0	0	12B
77	77	0	0	0	12B
78	78	0	0	0	12B
79	79	0	0	0	12B
80	80	0	0	0	12B
81	81	0	0	0	12B
82	82	0	0	0	12B
83	83	0	0	0	12B
84	84	0	0	0	12B
85	85	0	0	0	12B
86	86	0	0	0	12B
87	87	0	0	0	12B
88	88	0	0	0	12B
89	89	0	0	0	12B
90	90	0	0	0	12B
91	91	0	0	0	12B
92	92	0	0	0	12B
93	93	0	0	0	12B
94	94	0	0	0	12B
95	95	0	0	0	12B
96	96	0	0	0	12B

	Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
97	0	0	0	12B
98	0	0	0	12B
99	0	0	0	12C
100	0	0	0	12C
101	0	0	0	12C
102	0	0	0	12C
103	0	0	0	12C
104	0	0	0	12C
105	0	0	0	12C
106	0	0	0	12C
107	0	0	0	12C
108	0	0	0	12C
109	0	0	0	12C
110	0	0	0	12C
111	0	0	0	12C
112	0	0	0	12C
113	0	0	0	12C
114	0	0	0	12C
115	0	0	0	12C
116	0	0	0	12C
117	0	0	0	12C
118	0	0	0	12C
119	0	0	0	12C
120	0	0	0	12C
121	0	0	0	12C
122	0	0	0	12C
123	0	0	0	12C
124	0	0	0	12C
125	0	0	0	12C
126	0	0	0	12C
127	0	0	0	12C
128	0	0	0	12C
129	0	0	0	12C
130	0	0	0	12C
131	0	0	0	12D
132	0	0	0	12D
133	0	0	0	12D
134	0	0	0	12D
135	0	0	0	12D
136	0	0	0	12D
137	0	0	0	12D
138	0	0	0	12D
139	0	0	0	12D
140	0	0	0	12D
141	0	0	0	12D
142	0	0	0	12D
143	0	0	0	12D
144	0	0	0	12D
145	0	0	0	12D
146	0	0	0	12D
147	0	0	0	12D
148	0	0	0	12D
149	0	0	0	12D
150	0	0	0	12D
151	0	0	0	12D
152	0	0	0	12D
153	0	0	0	12D
154	0	0	0	12D
155	0	0	0	12D
156	0	0	0	12D
157	0	0	0	12D
158	0	0	0	12D
159	0	0	0	12D
160	0	0	0	12D
161	0	0	0	12D
162	0	0	0	12D

Base year:
Total of Column C/Total of Column B = Base Year

370182892.5 3942148.02 93.9038541

Base Year = 1993

TABLE 1 error

Table 1 Uniform building Value

Uniform Building Value

Base year	6, 7, 8 & 9	1, 2, 3, 4, 5, 10 & 11
1970	4114	3766
1971	5348	4896
1972	6583	6026
1973	7817	7155
1974	9051	8285
1975	10285	9415
1976	11519	10545
1977	12754	11675
1978	13988	12804
1979	15222	13934
1980	16456	15064
1981	17691	16194
1982	18925	17324
1983	20159	18453
1984	21393	19583
1985	22628	20713
1986	23862	21843
1987	25096	22973
1988	26330	24102
1989	27564	25232
1990	28799	26362
1991	30033	27492
1992	31267	28622
1993	32501	29751
1994	33736	30881
1995	34970	32011
1996	36204	33141
1997	37438	34271
1998	38673	35400
1999	39907	36530
2000	41141	37660

Use the 1970 values for all years prior to 1970

TABLE 2 #N/A

Construction Inflators by year and HSA
(Note: Use the 1960 Inflators for all years prior to 1960)
(For the FY94 Nursing Facility Rate Calculation Packet)

Year	1, 2 & 10	3, 4 & 5	11	6, 7, 8 & 9
1960	6.26	6.08	6.29	6.54
1961	5.67	5.52	5.66	5.87
1962	5.67	5.52	5.66	5.87
1963	5.67	5.52	5.66	5.87
1964	5.67	5.52	5.66	5.87
1965	5.67	5.52	5.66	5.87
1966	5.36	5.23	5.35	5.55
1967	5.1	4.97	5.08	5.28
1968	4.85	4.71	4.83	5.03
1969	4.61	4.48	4.59	4.79
1970	4.38	4.25	4.36	4.56
1971	4.01	3.89	3.98	4.15
1972	3.64	3.53	3.63	3.78
1973	3.36	3.26	3.36	3.48
1974	3.08	3	3.09	3.19
1975	2.83	2.77	2.8	2.91
1976	2.73	2.65	2.74	2.82
1977	2.57	2.48	2.55	2.68
1978	2.37	2.29	2.38	2.49
1979	2.18	2.12	2.21	2.32
1980	1.96	1.92	2.02	2.08
1981	1.8	1.76	1.86	1.91
1982	1.67	1.63	1.72	1.76
1983	1.54	1.5	1.57	1.65
1984	1.51	1.47	1.55	1.62
1985	1.48	1.45	1.5	1.59
1986	1.46	1.42	1.46	1.55
1987	1.44	1.4	1.43	1.52
1988	1.4	1.36	1.39	1.46
1989	1.35	1.33	1.35	1.41
1990	1.32	1.31	1.33	1.34
1991	1.29	1.29	1.3	1.31
1992	1.26	1.26	1.27	1.26
1993	1.25	1.24	1.25	1.23
1994	1.22	1.22	1.22	1.19
1995	1.2	1.2	1.19	1.17
1996	1.12	1.11	1.13	1.12
1997	1.1	1.09	1.1	1.1
1998	1.08	1.07	1.07	1.07
1999	1.04	1.04	1.04	1.04
2000	1.02	1.02	1.02	1.03
2001	1.00	1.00	1.00	1.00
2002	1.00	1.00	1.00	1.00

TABLE 3

Property Tax Inflator

HSA	Rate
1	1.05723
2	1.0395
3	1.0333
4	1.03302
5	1.03753
6	1.02368
7	1.02054
8	1.02613
9	1.01315
10	1.0815
11	1.03527

TABLE 4

Table 2 column

HSA	Column
1	1
2	1
3	2
4	2
5	2
6	4
7	4
8	4
9	4
10	1
11	3

Page	
1	
2	
3	
4	
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16	
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18	
19	
20	
21	
22	
23	Provider Participation fee is linked from page 4